MAIL TO:

ADMINISTRATIVE CONCEPTS, INC.
997 Old Eagle School Rd., Suite 215
Wayne, PA 19087-1706
www.visit-aci.com

ACE American Insurance Company
CLAIM FORM

Complete In Detail To Insure Prompt Handling

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading information concerning any material fact, commits a fraudulent insurance act. For residents of the following states, please see the reverse side: Colorado, Florida, Maryland, New Jersey, New York, Pennsylvania, Oregon, Virginia or District of Columbia

Group Plan or Program: Jefferson Lab _____ _____
Policyholder | Policy Number | Certificate/I.D. Number

Name of Insured Individual: _____
Last Name | First Name | Middle Initial

Present Address: _____
No. and Street | City or Town | State | Zip Code Country

Home Address: _____
No. and Street | City or Town | State | Zip Code Country

Telephone Number: 757-269-6380 Date of Birth: _____ Male Female (Circle One)

If payment is to be made to someone other than the Insured, who is to receive payment? _____

Relationship to insured: Address:

Date of Accident or Sickness:	Nature of Accident or Sickness:

If accident, describe fully how and where accident occurred:

If injured in play or practice of sport, indicate what sport:

Is the insured covered under any other group plan, health maintenance organization, government plan, or insurance policy?
Yes ☐ No ☐ Insurance Company: Policy Number:

INSURED OR PARENT MUST SIGN BELOW:	IF PAYMENT IS TO BE ASSIGNED TO PROVIDER, SIGN BELOW:
Authorization: I hereby authorize release to Administrative Concepts Inc., any and all information concerning advice, care or treatment provided to myself or any of my family which may be needed to process this claim.	Authorization: I hereby authorize payment of medical benefits to the medical provider identified on this form, for the service described.
Insured's Signature: Date:	Insured's Signature: Date:

Physician or Provider Information **(Please Attach Universal 1500 Form or Fill Out In Full Below)**

Date of First Symptom of Illness or Injury: _____ Date First Consulted you for this Condition: _____ Has Patient Ever Had Same or Similar Symptoms? Yes ☐ No ☐

Diagnosis: History of Illness or Injury:

Name of Referring Physician or Other Source:

For Services Related to Hospitalization (Give Dates) Admitted: _____
Discharged: _____

Name and Address of Facility Where Services Rendered: Was Laboratory Work Performed Outside Your Office? Yes ☐ No ☐
Lab Charges:

Date of Service	Place of Service	CPT Code	Description of Service	ICD-9	Charge

_____ _____ Will You Accept Assignment?: Yes ☐ No ☐ Total Charges: _____
Provider Signature Date

_____ _____ Tel. # _____
Print Provider's Name Provider's Address _____ Fax # _____
Tax I.D. #